Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of	)	
	)	WC Docket No. 02-60
Rural Health Care Support Mechanism	)	

ORDER

Adopted: November 16, 2007 **Released: November 19, 2007**

By the Commission: Chairman Martin and Commissioners Copps, Adelstein, Tate and McDowell issuing separate statements.

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I. INTRODUCTION

1. In this Order, we select participants for the universal service Rural Health Care (RHC) Pilot Program established by the Commission in the *2006 Pilot Program Order* pursuant to section 254(h)(2)(A) of the Communications Act of 1934, as amended by the Telecommunications Act of 1996 (1996 Act).[1] The initiation of the Pilot Program resulted in an overwhelmingly positive response from those entities the Commission intended to reach when it established the program last year – health care providers, particularly those operating in rural areas. Exceeding even our own high expectations, we received 81 applications representing approximately 6,800 health care facilities from 43 states and three United States territories. As detailed below, 69 of these applicants have demonstrated the overall qualifications consistent with the goals of the Pilot Program to stimulate deployment of the broadband infrastructure necessary to support innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute.[2]

2. Accordingly, selected participants will be eligible for universal service funding to support up to 85 percent of the costs associated with the construction of state or regional broadband health care networks and with the advanced telecommunications and information services provided over those networks.[3] In addition, because of the large number of selected participants, we modify the Pilot Program so that selected participants may be eligible for funding for the appropriate share of their eligible two-year Pilot Program costs over a three-year period beginning in Funding Year 2007 and ending in Funding Year 2009. By spreading the two-year costs over a three-year commitment period, we are able to increase the available support for selected participants from the amount established in the *2006 Pilot Program Order* to approximately $139 million in each funding year of the three-year Pilot Program. This will ensure that all qualifying applicants are able to participate in the Pilot Program and yet do so in an economically reasonable and fiscally responsible manner, well below the $400 million-dollar annual cap, and enable selected participants to have sufficient available support to achieve the goals and objectives demonstrated in their applications.[4] For the reasons discussed below, we also deny 12 applicants from participating in the Pilot Program because these applicants have not demonstrated they satisfy the overall criteria, principles, and objectives of the *2006 Pilot Program Order*.

3. In light of the many applications we received seeking funding and the wide range of network and related components for which support is sought, we further clarify the facilities and services that are eligible and ineligible for support to ensure that the Pilot Program operates to facilitate the goals set forth

[1] 47 U.S.C. § 254(h)(2)(A); 47 U.S.C. §§ 151 *et seq.*; Telecommunications Act of 1996, Pub. L. No. 104-104, 110 Stat. 56 (1996); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, para. 1 (2006) (*2006 Pilot Program Order*).

[2] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1. *See* Appendix B for a list of the Pilot Program selectees.

[3] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1.

[4] In the *2006 Pilot Program Order*, the Commission established a cap for the Pilot Program in an amount not to exceed the difference between $100 million and the amount committed under the existing RHC support mechanism for the Funding Year. *See id.*

in the *2006 Pilot Program Order*. For example, we clarify that eligible costs include the non-recurring costs for design, engineering, materials, and construction of fiber facilities and other broadband infrastructure; the non-recurring costs of engineering, furnishing, and installing network equipment; and the recurring and non-recurring costs of operating and maintaining the constructed network. We also clarify that ineligible costs include those costs not directly associated with network design, deployment, operations, and maintenance.

4. We provide specific guidance to the selected participants regarding how to submit existing FCC Forms to the universal service Fund Administrator, the Universal Service Administrative Company (USAC). For example, selected participants, in order to receive universal service support, must submit with the required FCC Forms detailed network costs worksheets concerning their proposed network costs, certifications demonstrating universal service support will be used for its intended purposes, and letters of agency from each participating health care provider. In order to receive reimbursement, selected applicants must also submit, consistent with existing processes and requirements, detailed invoices showing actual incurred costs of project build-out and, if applicable, network design studies. We also require that selected participants' network build-outs be completed within five years of receiving an initial funding commitment letter (FCL). As discussed below, selected participants that fail to comply with the terms of this Order and with the USAC administrative processes will be prohibited from receiving support under the Pilot Program. We also set forth data reporting requirements for selected participants where participants must submit to USAC and to the Commission quarterly reports containing data on network build-out and use of Pilot Program funds. This information will inform the Commission of the cost-effectiveness and efficacy of the different state and regional networks funded by the Pilot Program and of whether support is being used in a manner consistent with section 254 of the 1996 Act, and the Commission's rules and orders.

5. We also address various requests for waivers of Commission rules filed by applicants concerning participation in the Pilot Program. Among other things, we deny waiver requests of the Commission's rule requiring that Pilot Program selected participants competitively bid their proposed network projects. In doing so, we reaffirm that the competitive bidding process is an important safeguard for ensuring universal service funds are used wisely and efficiently by requiring the most cost-effective service providers be selected by Pilot Program participants.

6. In addition, we establish an audit and oversight mechanism for the Pilot Program to guard against waste, fraud, and abuse, and to ensure that funds disbursed through the Pilot Program are used for appropriate purposes. In particular, the Commission will conduct audits of all selected participants and, if necessary, investigations of any selected participants to determine compliance with the Pilot Program, Commission rules and orders, and section 254 of the 1996 Act. As discussed in greater detail below, because audits or investigations may provide information showing that a beneficiary or service provider failed to comply with the statute or Commission rules and orders, such proceedings can reveal instances in which Pilot Program disbursement awards were improperly distributed or used in a manner inconsistent with the Pilot Program. To the extent we find funds were not used properly, USAC or the Commission may recover such funds and the Commission may assess forfeitures or pursue other recourse.

7. Finally, selected participants shall coordinate the use of their health care networks with the Department of Health and Human Services (HHS) and, in particular, with its Centers for Disease Control and Prevention (CDC) in instances of national, regional, or local public health emergencies (*e.g.*, pandemics, bioterrorism). In such instances, where feasible, selected participants shall provide access to their supported networks to HHS, including CDC, and other public health officials. Similarly, selected participants shall use Pilot Program funding in ways that are consistent with HHS' health information technology (IT) initiatives that "provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of

health care."[5] Accordingly, where feasible, selected participants, as part of their Pilot Program network build-out projects shall: (1) use health IT systems and products that meet interoperability standards recognized by the HHS Secretary; (2) use health IT products certified by the Certification Commission for Healthcare Information Technology; (3) support the Nationwide Health Information Network (NHIN) architecture by coordinating their activities with the organizations performing NHIN trial implementations; (4) use resources available at HHS's Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health Information Technology; (5) educate themselves concerning the Pandemic and All Hazards Preparedness Act and coordinate with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and (6) use resources available through CDC's Public Health Information Network (PHIN) to facilitate interoperability with public health organizations and networks.

II. BACKGROUND

A. Rural Health Care Support Mechanism

8. In the 1996 Act, Congress specifically intended that rural health care providers be provided with "an affordable rate for the services necessary for the provision of telemedicine and instruction relating to such services."[6] In 1997, the Commission implemented this statutory directive by adopting the current RHC support mechanism, funded by monies collected through the universal service fund.[7] Consistent with Congress's directive in 47 U.S.C. § 254(h)(1)(A), the Commission established the rural health care program to ensure that rural health care providers pay no more than their urban counterparts for their telecommunications needs in the provision of health care services.[8] To accomplish this, the Commission concluded that telecommunications carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account.[9] The Commission also adopted mechanisms to provide support for limited toll-free access to an Internet service provider.[10] Finally, the Commission adopted an annual cap of $400 million for universal service support for rural health care providers.[11] The Commission based its conclusions on analyses of the condition of the rural health care community and on the state of technology in existence at that time.[12]

9. Since 1997, the Commission has made several changes to the RHC support mechanism to increase its utility and to reflect technological changes. For example, in 1999, after determining that only a small number of rural health care providers qualified for discounts in the original funding cycle (which

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[5] *See* Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator, Exec. Order No. 13335, 69 FR 24059 (April 27, 2004).

[6] *See* Joint Explanatory Statement of the Committee of Conference, 104th Cong., 2d Sess. at 133 (1996); *see also* 47 U.S.C. § 254(b)(3), (h).

[7] *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776 (1997) (*Universal Service First Report and Order*) (subsequent history omitted).

[8] *See, e.g.*, 47 U.S.C. § 254(h)(1)(A); *Universal Service First Report and Order*, 12 FCC Rcd at 9093-9161, paras. 608-749; 47 C.F.R. Part 54, Subpart G.

[9] *Universal Service First Report and Order*, 12 FCC Rcd at 9093, para. 608.

[10] *Id.*

[11] 47 C.F.R. § 54.623; *Universal Service First Report and Order*, 12 FCC Rcd at 9141, para. 705.

[12] *See Universal Service First Report and Order*, 12 FCC Rcd at 9094, n.1556 (relying on material supplied by the Advisory Committee on Telecommunications and Health Care and the Federal-State Joint Board on Universal Service).

covered the period from January 1, 1998, through June 30, 1999), the Commission reevaluated the structure of the RHC support mechanism.[13] Among other things, the Commission simplified the urban/rural rate calculation and encouraged participation by consortia.[14] The Commission also provided additional guidance regarding the types of entities that are not eligible to receive support, determining that the definition of "health care provider" does not include nursing homes, hospices, other long-term care facilities, or emergency medical service facilities.[15] The Commission declined to clarify further the definition of "health care provider" or to provide additional support for long distance telecommunications service.[16]

10. In 2002, the Commission issued a Notice of Proposed Rulemaking to review the RHC support mechanism.[17] In particular, the Commission sought comment on whether it should: clarify how the Commission treats eligible entities that also perform functions that are outside the statutory definition of "health care provider"; provide support for Internet access; or change the calculation of discounted services, including the calculation of urban and rural rates.[18] In addition, the Commission sought comment on whether and how to streamline the application process; allocate funds if demand exceeds the annual cap; modify the current competitive bidding rules; and encourage partnerships with clinics at schools and libraries.[19] The Commission sought further comment on other issues concerning the structure and operation of the RHC support mechanism, including measures to prevent waste, fraud, and abuse.[20]

11. In 2003, the Commission released the *2003 Report and Order and FNPRM* that modified its rules to improve the effectiveness of the RHC support mechanism.[21] Among other changes, the *2003 Report and Order and FNPRM*: (1) clarified that dedicated emergency departments of rural for-profit hospitals that participate in Medicare are "public" health care providers and are eligible to receive prorated rural health care support; (2) clarified that non-profit entities that function as rural health care providers on a part-time basis are eligible for prorated rural health care support; (3) revised the rules to provide a 25 percent discount off the cost of monthly Internet access for eligible rural health care providers; (4) revised the rules to allow rural health care providers to compare the urban and rural rates for functionally similar services as viewed from the perspective of the end user; (5) revised the rules to allow rural health care providers to compare rural rates to urban rates in any city with a population of at least 50,000 in the same state; and (6) revised the rules to allow rural health care providers to receive discounts for satellite services even where alternative terrestrial-based services may be available, but

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[13] *Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, CC Docket Nos. 97-21 and 96-45, Sixth Order on Reconsideration in CC Docket No. 97-21 and Fifteenth Order on Reconsideration in CC Docket No. 96-45, 14 FCC Rcd 18756, 18760-61, para. 7 (1999) (*Fifteenth Order on Reconsideration*) (noting that there were 2,500 initial applications, and only a small fraction received funding in the first funding cycle).

[14] *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18762, para. 9.

[15] *Id.* at 18786, para. 48. The Commission found that, given the specific categories of health care providers listed in section 254(h)(5)(B), if Congress had intended to include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities, it would have done so explicitly. *Id.*

[16] *Id.* at 18773, 18786, paras. 26, 48-49.

[17] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 17 FCC Rcd 7806 (2002) (*2002 NPRM*).

[18] *Id.* at 7812-7825, paras. 13-50.

[19] *Id.* at 7825-7828, paras. 51-61.

[20] *Id.* at 7826, para. 62.

[21] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546 (2003) (*2003 Report and Order and FNPRM*).

capped such support at the amount providers would have received if they purchased functionally similar terrestrial-based alternatives.[22] These changes were implemented beginning in Funding Year 2004.[23]

12. In an accompanying Further Notice of Proposed Rulemaking, the Commission also sought comment on the definition of "rural area" for the rural health care program.[24] In 1997, the Commission adopted the definition of "rural" used by the Office of Rural Health Policy (ORHP) at that time.[25] ORHP, however, subsequently discontinued using that definition, and adopted a new definition.[26] The Commission also sought comment on whether it should also use the new definition ORHP had adopted or use a different definition.[27] The Commission also sought comment on whether additional modifications to the Commission's rules were appropriate to facilitate the provision of support to mobile rural health clinics for satellite services and whether other measures were necessary to further streamline the administrative burdens associated with applying for support.[28]

13. In 2004, the Commission released a *Second Report and Order and Further Notice of Proposed Rulemaking*, which established a new definition of "rural" for purposes of the RHC support mechanism, effective as of Funding Year 2005.[29] Under the new definition, a rural area is one that is not located within or near a large population base. Specifically, a "rural area" is an area that: (1) is entirely outside of a Core Based Statistical Area (CBSA);[30] (2) is within a CBSA that does not have any urban area with a population of 25,000 or greater; [31] or (3) is in a CBSA that contains an urban area with a population of 25,000 or greater, but is within a specific census tract[32] that itself does not contain any part

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[22] *See generally id.*

[23] Funding Year 2003 for the rural health care program ended June 30, 2004, and Funding Year 2004 began July 1, 2004. Because the Commission chose not to introduce changes to the program in the middle of a funding year, the modifications to the program adopted in the *2003 Report and Order and FNPRM* were implemented beginning with Funding Year 2004. *Id.* at 24577, para. 60.

[24] *Id.* at 24578, para. 63.

[25] *Universal Service First Report and Order*, 12 FCC Rcd at 9115-9116, para 649.

[26] ORHP has adopted the Rural Urban Commuting Area (RUCA) system for rural designation, using 2000 Census data. *See* HRSA, Rural Health Policy: Geographic Eligibility for Rural Health Grant Programs *at* http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp (last visited Nov. 15, 2007).

[27] *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24578, para. 64.

[28] *Id.* at 24579-81, paras. 65-66, 69.

[29] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24613 (2004) (*Second Report and Order and FNPRM*).

[30] A CBSA is a statistical geographic entity consisting of the county or counties associated with at least one core of at least 10,000 people plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties containing the core. A core is a densely settled concentration of population, comprising either an urbanized area (of 50,000 or more population) or an urban cluster (of 10,000 to 49,999 population) defined by the Census Bureau. *See Standards for Defining Metropolitan and Micropolitan Statistical Areas*, Office of Management and Budget, 65 FR 82228, no. 249 (Dec. 27, 2000).

[31] The urbanized population is the population contained in the urban area (urbanized area or urban cluster) at the core of the CBSA, as well as all other urban areas in the CBSA. Urbanized areas and urban clusters are areas of "densely settled territory," as defined by the Census Bureau. *See* U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A. A list of urban areas for the 2000 Census can be found *at* http://www.census.gov/geo/www/ua/ctrlplace.html (last visited Nov. 15, 2007).

[32] Census tracts are small, relatively permanent statistical subdivisions of a county or statistically equivalent entity. Tracts in the United States, Puerto Rico and the U.S. Virgin Islands generally contain between 1,500 and 8,000 (continued....)

of a place or urban area with a population of greater than 25,000.[33] The Commission also revised its rules to expand funding for mobile rural health care services by subsidizing the difference between the rate for satellite service and the rate for an urban wireline service with a similar bandwidth.[34] Further, the Commission established June 30 as a fixed deadline for applications for support under the RHC support mechanism, and permitted rural health care providers in states that are entirely rural to receive support for advanced telecommunications and information services under section 254(h)(2)(A).[35] Finally, the Commission sought comment on whether it should increase the percentage discount that rural health care providers receive for Internet access and whether infrastructure development should be funded, as well as further modifications to the existing RHC support mechanism.[36]

B. Rural Health Care Pilot Program

14. Despite the modifications the Commission has made to the RHC support mechanism, the program has yet to fully achieve the benefits intended by the statute and the Commission. Notably, although $400 million dollars per year has been authorized for funding this program, since the program's inception in 1998, the program generally has disbursed less than 10 percent of the authorized funds each year.[37] Although there are a number of technical factors that may explain the underutilization of this important program, it has become apparent that, despite prior Commission efforts, health care providers continue to lack access to the broadband facilities needed to support the types of advanced telehealth applications, like telemedicine, that are so vital to bringing medical expertise and the advantages of modern health care technology to rural areas of the country. Without access to dedicated broadband capacity, many of these real-time telehealth applications are simply not being deployed or deployed too slowly or with minimal capabilities in rural areas.

15. In response to this problem, in September 2006, the Commission released the *2006 Pilot Program Order*.[38] This order was expressly designed to explore, from the ground up, how to best encourage the deployment of broadband facilities necessary to support the enormous benefits of telehealth and telemedicine applications.[39] This order established a two-year Pilot Program to examine how RHC support mechanism funds can be used to enhance public and non-profit health care providers' access to advanced telecommunications and information services.[40] The Commission established the Pilot Program under the authority of section 254(h)(2)(A) of the 1996 Act, which called for the Commission to establish competitively neutral rules to enhance access to advanced telecommunications and information

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people, with an optimum size of 4,000. *See* U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A.

[33] Places include census-designated places, consolidated cities and incorporated places. *See* U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A.

[34] *Second Report and Order and FNPRM*, 19 FCC Rcd at 24626-28, paras. 29-32.

[35] 47 U.S.C. § 254(h)(2)(A); 47 C.F.R. §§ 54.621, 54.623; *Second Report and Order and FNPRM*, 19 FCC Rcd at 24628-29 and 24631-34, paras. 33-34 and paras. 38-44.

[36] *Second Report and Order and FNPRM*, 19 FCC Rcd at 24635, paras. 47-53. The issues raised in the *FNPRM* remain pending.

[37] *See* USAC, Annual Report 2006 at 5, *available at* http://www.usac.org/_res/documents/about/pdf/usac-annual-report-2006.pdf (last visited Nov. 15, 2007) (*USAC 2006 Annual Report*); USAC, Annual Report 2002 at 2, *available at* http://www.usac.org/_res/documents/about/pdf/usac-annual-report-2002.pdf (last visited Nov. 15, 2007) (*USAC 2002 Annual Report*).

[38] *2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1.

[39] *Id.*

[40] *Id.*

services for health care providers.[41] The long-term goal of the Pilot Program is to provide the Commission with a more complete and practical understanding of how to ensure the best use of the available RHC support mechanism funds to support a broadband, nationwide health care network (expressly including rural areas) so that the Commission can reform the overall RHC support mechanism.[42]

16. In the *2006 Pilot Program Order*, the Commission sought to facilitate broadband deployment to health care providers in order to bring the benefits of innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute.[43] To accomplish this task, the Commission stated the Pilot Program would fund a significant portion of the costs of deploying dedicated broadband capacity that connects multiple public and non-profit health care providers, within a state or region, as well as providing the "advanced telecommunications and information services" that ride over that network.[44] The Commission specified that the Pilot Program would fund up to 85 percent of the costs incurred by the selected participants to deploy a state or regional dedicated broadband health care network and, at the applicant's discretion, to connect that network to Internet2, National LambdaRail (NLR), or the public Internet.[45] Consistent with the mandate provided in section 254(h)(2)(A) and the general principles of universal service, participation was opened to all eligible public and non-profit health care providers, but applicants were required to include in their proposed networks public and non-profit health care providers that serve rural areas.[46] The Commission also established (*via* the competitive bidding process) that the Pilot Program be technology neutral,

[41] *See* 47 U.S.C. § 254(h)(2)(A). Section 254(h)(2)(A) provides the Commission broad discretionary authority to fulfill this statutory mandate. *See Federal State Joint Board on Universal Service Schools Libraries Universal Service Support Mechanism Rural Health Care Support Mechanism Lifeline and Link-Up*, Order, 20 FCC Rcd 16883, 16899 (2005). In *Texas Office of Public Utility Counsel v. FCC*, the United States Court of Appeals for the Fifth Circuit upheld the Commission's authority under section 254(h)(2)(A) to provide universal service support for "advanced services" to non-rural health care providers. 18 F.3d 393, 446 (5th Cir. 1999), *aff'g in part, ref'g in part, and remanding in part, Federal State Joint Board on Universal Service*, CC Docket No. 96-45, First Report and Order, 12 FCC Rcd 8776 (1997). In reaching this conclusion, the court determined that Congress intended to allow the Commission broad authority to implement section 254(h)(2)(A) of the 1996 Act. *Id.* at 446. Pursuant to this authority the Commission adopted the *2006 Pilot Program Order* to "provide funding to support the construction of state or regional broadband networks and services provided over those networks." *2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1.

[42] *2006 Pilot Program Order*, 21 FCC Rcd at 11113, para. 9. Upon completion of the Pilot Program, the Commission intends to issue a report detailing the results of the Pilot Program and the status of the RHC support mechanism generally, and to recommend any changes necessary to improve existing RHC support mechanism. In addition, the Commission intends to incorporate the information it gathers as part of the Pilot Program into the record of any subsequent proceeding. *Id.* at 9.

[43] *Id.* at 11111, 11113, paras. 1, 9.

[44] *Id.* at 11114, para. 10.

[45] *See id.* at 11115, para. 14; *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order on Reconsideration, 22 FCC Rcd 2555 (2007) (*Pilot Program Reconsideration Order*) (reconsidering the *2006 Pilot Program Order* to permit funding to connect a state or regional health care network to NLR or to the public Internet, in addition to Internet2). Internet2 and NLR are not-for-profit, nationwide network backbones, dedicated to educational, clinical, and research goals. *See, e.g.*, Internet 2, About Us, at http://www.internet2.edu/about/ (last visited Nov. 15, 2007) and NLR, About National LambdaRail, at http://www.nlr.net/about/ (last visited Nov. 15, 2007).

[46] *2006 Pilot Program Order*, 21 FCC Rcd at 11114, para. 10.

permitting eligible health care providers to choose any technology and provider of broadband connectivity needed to provide telehealth, including telemedicine, services.[47]

17. Applicants selected under the Pilot Program must use the funds for the purposes specified in their applications, subject to any required modifications in this Order.[48] Authorized purposes for funds awarded under the Pilot Program include the costs of deploying transmission facilities and advanced telecommunications and information services, including associated non-recurring and recurring costs, as well as conducting initial network design studies.[49] Funding for the Pilot Program was initially set at an amount not to exceed the difference between $100 million and the amount committed under the Commission's existing RHC support mechanism for the relevant funding year.[50]

18. Except as otherwise expressly specified, the Pilot Program utilizes the same program definitions as, and is intended to function within the confines of, the existing RHC support mechanism. The RHC support mechanism utilizes the statutory definition of "health care provider" established in section 254(h)(7)(b) of the 1996 Act.[51] Specifically, section 254(h)(7)(b) defines "health care provider" as:

(i) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
(ii) community health centers or health centers providing health care to migrants;
(iii) local health departments or agencies;
(iv) community mental health centers;
(v) non-for-profit hospitals;
(vi) rural health clinics; and
(vii) consortia of health care providers consisting of one or more entities described in clauses (i) through (vi).[52]

Accordingly, under both the existing RHC support mechanism and the Pilot Program, only eligible health care providers and consortia that include eligible health care providers may apply for and receive discounts for eligible services.[53]

19. In the *2006 Pilot Program Order*, the Commission further specified the minimum types of information applicants should include in their applications to be selected to be eligible to receive funding. Applicants were instructed to present a strategy for aggregating the specific needs of health care providers within a state or region, including providers that serve rural areas, and for leveraging existing technology

[47] *Id.* at 11114, para. 11. As discussed above, *see supra* para. 15 and note 41, the Commission established the Pilot Program under the authority of section 254(h)(2)(A) of the 1996 Act. The Commission has previously determined that section 254(e) of the 1996 Act, which provides that "only an eligible telecommunications carrier designated under section 214(e) shall be eligible to receive specific Federal universal service support," is inapplicable to section 254(h)(2). *See Universal Service First Report and Order*, 12 FCC Rcd at 9086-87, paras. 592-94. Accordingly, bidders on selected participants' proposals need not be eligible telecommunications carriers to receive Pilot Program funds if selected. *See infra* para. 119 addressing service provider eligibility.

[48] *2006 Pilot Program Order*, 21 FCC Rcd at 11115, para. 14.

[49] *Id.* at 11115-16, paras. 14-15.

[50] *Id.* at 11115, para. 12 ($100 million represents 25 percent of the total $400 million annual RHC funding cap).

[51] *Id.* at 11111, n.4.

[52] 47 U.S.C. § 254(h)(7)(b). The Commission has determined dedicated emergency departments of rural for-profit hospitals that participate in Medicare constitute rural health care clinics. *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24553-55, paras. 13, 16.

[53] *See* 47 C.F.R. § 54.601(a)(1), (c)(1).

to adopt the most efficient and cost-effective means of connecting those providers.[54] The Commission stated that proposals connecting only a *de minimis* number of rural health care providers would not be considered.[55] The *2006 Pilot Program Order* also included the following eleven specific criteria which applicants were instructed to address in their applications.[56]

1) Identify the organization that will be legally and financially responsible for the conduct of activities supported by the fund;
2) Identify the goals and objectives of the proposed network;
3) Estimate the network's total costs for each year;
4) Describe how for-profit network participants will pay their fair share of the network costs;
5) Identify the source of financial support and anticipated revenues that will pay for costs not covered by the fund;
6) List the health care facilities that will be included in the network;
7) Provide the address, zip code, Rural Urban Commuting Area (RUCA) code, and phone number for each health care facility participating in the network;
8) Indicate previous experience in developing and managing telemedicine programs;
9) Provide a project management plan outlining the project's leadership and management structure, as well as its work plan, schedule, and budget;
10) Indicate how the telemedicine program will be coordinated throughout the state or region; and
11) Indicate to what extent the network will be self sustaining once established.

20. On February 6, 2007, the Commission released the *Pilot Program Reconsideration Order*.[57] In that order, the Commission allowed applicants either to pre-select Internet2 or NLR as a nationwide backbone provider,[58] or to seek competitive bids for their nationwide backbone providers through the normal competitive bidding process.[59]

21. On March 8, 2007, the Commission received OMB approval of the information collection requirements contained in the *2006 Pilot Program Order*.[60] Applications to participate in the Pilot Program for Funding Year 2006 were due no later than May 7, 2007.[61]

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[54] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 16.

[55] *Id.*

[56] *Id.* at 11116-17, para. 17. In addition, successful applicants were instructed to demonstrate that they have a viable strategic plan for aggregating usage among health care providers within their state or region. *Id.* at 11116, para. 16. In selecting participants for the Pilot Program, the Commission also indicated that it would consider whether an applicant has a successful track record in developing, coordinating, and implementing a successful telehealth/telemedicine program within their state or region, and the number of health care providers that are included in the proposed network, with considerable weight to applications that propose to connect the rural health care providers in a given state or region. *Id.*

[57] *Pilot Program Reconsideration Order*, 22 FCC Rcd at 2556, para. 5.

[58] The Commission waived, on its own motion, the rural health care program's competitive bidding and cost-effectiveness rules for Pilot Program applicants where an applicant proposes to pre-select Internet2 or NLR as its nationwide backbone provider. *Id.* at 2558, para. 8. The Commission did not otherwise waive its competitive bidding or cost-effectiveness rules.

[59] *Id.* at 2555, para. 1. In addition, the Commission extended the deadline for applications to the Pilot Program from 30 days after Office of Management and Budget (OMB) approval of the information collection requirements contained in the *2006 Pilot Program Order* to 60 days after OMB approval. *Id.* at 2558, para. 9.

[60] *Wireline Competition Bureau Announces OMB Approval of the Rural Health Care Pilot Program Information Collection Requirements and the Deadline for Filing Applications*, WC Docket No. 02-60, Public Notice, 22 FCC Rcd 4770 (Wireline Comp. Bur. 2007) (*OMB Public Notice*).

III. DISCUSSION

22. The *2006 Pilot Program Order* generated overwhelming interest from the health care community. We received 81 applications representing approximately 6,800 health care providers. Of these, 69 applications covering 42 states and three United States territories demonstrate the overall qualifications consistent with the goals, objectives, and other criteria outlined in the *2006 Pilot Program Order* necessary to advance telehealth and telemedicine in their areas. Specifically, they describe strategies for aggregating the specific needs of health care providers within a state or region, including providers serving rural areas; provide strategies for leveraging existing technology to adopt the most efficient and cost-effective means of connecting those providers; describe previous experience in developing and managing telemedicine programs; and detail project management plans.[62] Rather than limit participation to a select few among the 69 qualified applicants, we find that it would be in the best interests of the Pilot Program, and appropriate as a matter of universal service policy, to accommodate as many of these qualified applicants as possible.

23. Moreover, having more participants will enable us to collect more data and thus enhance our ability to critically evaluate the Pilot Program. To accommodate the 69 qualified applicants in an economically reasonable and fiscally responsible manner, including remaining well within the existing $400 million annual RHC support mechanism cap, we modify the Pilot Program to spread funding equally over a three-year period.[63] Specifically, total available support for Year One of the Pilot Program (Funding Year 2007 of the existing RHC support mechanism), Year Two (Funding Year 2008 of the existing RHC support mechanism), and Year Three (Funding Year 2009 of the existing RHC support mechanism) of the Pilot Program will be approximately $139 million per funding year. With this modification, we are thus able to select all of the 69 qualified applicants as eligible to participate in the Pilot Program. Finally, selected participants shall work with HHS and, in particular, CDC, to make the health care networks funded by the Pilot Program available for use in instances of nationwide, regional, or local public health emergencies (*e.g.*, pandemics, bioterrorism). Selected participants shall also use funding in a manner consistent with HHS's health IT initiatives.[64]

A. Overview of Applicants

24. Consistent with the Commission's goal in the *2006 Pilot Program Order* to learn from the health care community through the design of a bottom-up application process, selected participants proffered a wide array of proposals to construct new health care networks or to upgrade existing networks and network components in an efficient manner. The selected proposals range from small-scale, local networks to large-scale, statewide or multi-state networks. Examples of applicants proposing small-scale networks include Mountain States Health Alliance which seeks $54,400 to connect two rural Virginia hospitals to an existing network consisting of 11 Tennessee hospitals.[65] Rural Healthcare Consortium of Alabama seeks $232,756 to connect four critical access hospitals in rural Alabama to enable teleradiology, lab information systems, video conferencing, and secure networking with academic medical centers and universities.[66]

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[61] *Id.* at 4771.

[62] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, paras. 16-17.

[63] *See* 47 C.F.R. § 54.623.

[64] *See supra* para. 7, *infra* Part III.E.6; *see also* Appendix D.

[65] Mountain States Health Alliance Application at 1.

[66] Rural Healthcare Consortium of Alabama Application at 1-3.

25. Other applicants propose networks much larger in scope. For instance, Tennessee Telehealth Network (TTN) seeks approximately $7.8 million to expand upon the existing Tennessee Information Infrastructure, a pre-existing broadband network serving state, local, and educational agencies in Tennessee.[67] Upon completion of the project, TTN's network will reach more than 440 additional health care providers throughout the state enabling it to bring the benefits of innovative telehealth, such as access to specialists in urban areas, to rural sites.[68] In addition, certain applicants plan to connect multi-state networks, such as New England Telehealth Consortium (NETC) which seeks approximately $25 million to connect 555 sites in Vermont, New Hampshire, and Maine to the Northern Crossroads network, enabling connectivity to hospitals and universities throughout New England, including Rhode Island, Massachusetts, and Connecticut.[69] NETC's resulting network would facilitate expansive telemedicine benefits, including remote trauma consultations, throughout the multi-state region.[70]

26. Numerous applicants also demonstrate the serious need to deploy broadband networks for telehealth and telemedicine services to the rural areas of the nation where the needs for these services are most acute. For example, Pacific Broadband Telehealth Demonstration Project seeks to connect Hawaii and 11 Pacific Islands to one broadband network in the region where transportation costs are extremely high and health care specialists are concentrated mainly in the region's urban centers such as Honolulu.[71]

27. Similarly, Health Care Research & Education Network convincingly demonstrates its state's need for expanded telemedicine services: North Dakota is an extremely rural state where 42 of its 53 counties include 30 percent or more residents living at or below 200 percent of the Federal Poverty Guidelines.[72] Part or all of 83 percent of North Dakota's counties are designated as health professional shortage areas,[73] and 94 percent are designated as mental health shortage areas.[74] To help alleviate these hardships, the University of North Dakota seeks to construct a high-speed data network to connect, *via* the existing state fiber network, Stagenet, its medical school's four main campus sites and clinical medical sites to five rural North Dakota health care facilities.[75] Doing so will allow for research which would greatly accelerate the ability to bring contemporary treatment options to rural areas.[76]

28. The Wyoming Telehealth Network also demonstrates the need for broadband infrastructure for health care use. In its application, it explains that Wyoming is an extremely low populous and rural

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[67] Tennessee Telehealth Network Application at 8, 12.

[68] *Id.* at 4, 6-7.

[69] New England Telehealth Consortium Application at 4.

[70] *Id.* at 15-16.

[71] Pacific Broadband Telehealth Demonstration Project Application at 1-2.

[72] *See 2007 Poverty Guidelines for the 48 Contiguous States and the District of Columbia*, 72 Fed. Reg. 3147-48 (2007). The Federal Poverty Guideline (FPG) is a measure used as an eligibility criterion for Federal programs, and is updated annually to reflect changes in the Consumer Price Index (CPI). *See id.* The FPG is currently used as a factor in the calculation for determining eligibility for the universal service low-income (Lifeline/Link-Up) program. *See Lifeline and Link-Up*, WC Docket No. 03-109, Report and Order and Further Notice of Proposed Rulemaking, 19 FCC Rcd 8302, 8308, para. 10 (2004).

[73] 42 C.F.R. § 5.2. Health professional(s) shortage area means any of the following which the Secretary determines has a shortage of health professional(s): (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility.

[74] *See id.*

[75] Health Care Research & Education Network Application at 8, 12-23.

[76] *Id.* at 16.

state, suffering from a severe shortage of health care providers. Wyoming ranks 45th in physicians per 100,000 people, and has only 18 psychiatrists, four certified psychological practitioners, and two school psychologists statewide. Wyoming Telehealth Network's proposed network will extend the reach of health care professionals by linking the entire state's 72 hospitals, community mental health centers, and substance abuse centers, which will enable these facilities to transmit data to one another and videoconference.[77] As these and other applications demonstrate, health care providers in rural areas need access to broadband facilities for telehealth and telemedicine services to be available in rural areas.

29. Some applicants request Pilot Program funding to support build-out to tribal lands. For example, Tohono O'odham Nation Department of Information Technology (Nation) seeks funding to connect three of the Nation's remote health care facilities to Internet2 and to Arizona health care providers with existing networks to facilitate implementation of a comprehensive telemedicine program for the Nation that will enable the Nation to connect into a nationwide backbone of networks.[78] The Nation's planned dedicated broadband network will result in a comprehensive health care delivery system that reaches even its most remote geographic areas – a particularly important goal considering the Nation's extremely limited public transportation system.[79]

30. We find that the selected participants demonstrate a viable strategy for effective utilization of Pilot Program support consistent with the principles established in the *2006 Pilot Program Order*, and sufficiently set forth how their networks will meet the detailed Pilot Program criteria set forth in the *2006 Pilot Program Order*. As discussed in detail below, while we find that the selected applications overall satisfy the criteria set forth in the *2006 Pilot Program Order*, many applicants must submit additional information to USAC to ensure that fund commitments and disbursements will be consistent with section 254 of the 1996 Act, this Order, and the Commission's rules and orders.[80]

B. Scope of Pilot Program and Selected Participants

31. In the *2006 Pilot Program Order*, the Commission stated, "[o]nce we have determined funding needs of the existing program, we will fund the Pilot Program in an amount that does not exceed the difference between the amount committed under our existing program for the current year and $100 million."[81] We estimated that approximately $55-60 million would be available for the Pilot Program, based on our past experience and estimates of funding requests received under the existing program for Funding Year 2006.[82] In the *2006 Pilot Program Order*, we also established the Pilot Program as a two-year program.[83]

32. *Funding Cap.* In light of the overwhelming need for the Pilot Program funding to build-out dedicated health care network capacity to support telehealth and telemedicine, we increase the funding cap amount from that set in the *2006 Pilot Program Order* to approximately $139 million for each year of the Pilot Program. We find this modification necessary to enable the 69 qualified applicants to implement their plans to the fullest extent possible.[84] In particular, we believe this increased amount of Pilot Program funding will enable participants to fully realize the benefits to telehealth and telemedicine

[77] Wyoming Telehealth Network Application at 1, 13-16.

[78] Tohono O'odham Nation Department of Information Technology Application at 4.

[79] *Id.* at 3.

[80] *See infra* paras. 83-95.

[81] *2006 Pilot Program* Order, 21 FCC Rcd at 11115, para. 12.

[82] *Id.* at 11115, para. 12, n.17.

[83] *Id.* at 11115, para. 13, n.18

[84] We do not disturb the overall $400 million cap on the RHC support mechanism. *See* 47 C.F.R. § 54.623(a).

services by making universal service support available for significant build-out of dedicated broadband network capacity. Increased support will also provide the Commission with an RHC Pilot Program extensive enough to soundly evaluate and to serve as a basis to propose to modify the existing RHC support mechanism, all without requiring us to reject otherwise compliant applications. Although available yearly Pilot Program support is higher than we originally contemplated in the *2006 Pilot Program Order*, this amount is still well below the $400 million cap for each funding year of the existing RHC support mechanism (even when combined with the most recent disbursements under the existing RHC support mechanism of $41 million), and therefore remains well within the existing parameters of economic reasonability and fiscal responsibility.[85]

33. *Duration of Pilot Program.* To continue to maintain fiscal discipline, we modify the duration of the Pilot Program to require that commitments for the two-year program costs identified by selected participants in their applications occur over a three-year period. Funding the selected applications over a three-year period at somewhat lower levels than requested based on a two-year program will better serve goals of section 254(h)(2)(A) of the 1996 Act because it provides us with sufficient flexibility to support more expansive network build-outs, thereby significantly enhancing health care providers' access to broadband services and enabling such access to occur considerably quicker than it otherwise would.[86] Spreading commitments over a three-year period will also ensure that the Program moves forward seamlessly to facilitate uninterrupted rural telehealth/telemedicine network build-outs, while balancing the need for economic reasonableness and responsible fiscal management of the program, including by staying well within the $400 million dollar RHC mechanism cap.[87] In addition, expansion of the Pilot Program's duration, as well as increasing available aggregate support, will provide greater certainty of support to applicants that requested funding for multiple years, and will obviate the need for reapplications during the duration of the Pilot Program. Accordingly, the Pilot Program will begin in Funding Year 2007 and end in Funding Year 2009 of the existing RHC support mechanism.[88]

34. *Administration of Funding Year 2006 Funds.* In establishing the Pilot Program duration, we apply to Funding Year 2007 the moneys that USAC already collected in Funding Year 2006 for the Pilot Program. Because we did not receive approval from the OMB until March 8, 2007, only two months prior to the application deadline of May 7, 2007, and because applicants could not meet the June 30, 2007, deadline for submitting Funding Year 2006 forms to USAC, we find it impracticable to begin the Pilot Program in Funding Year 2006 as originally contemplated.[89] Consequently, we begin the USAC application, commitment, and disbursement process for the Pilot Program with Funding Year 2007. Total available support for Year One of the Pilot Program (Funding Year 2007 of the existing RHC support mechanism), Year Two (Funding Year 2008 of the existing RHC support mechanism), and Year Three

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[85] *See* 47 U.S.C. § 254(h)(2)(A). *See also 2006 Pilot Program Order*, 21 FCC Rcd at 11115, para. 12; USAC, Annual Report 2006 at 4, *available at* http://www.usac.org/_res/documents/about/pdf/usac-annual-report-2006.pdf (*USAC 2006 Annual Report*) (last visited Nov. 8, 2007).

[86] *See* 47 U.S.C. § 254(h)(2)(A).

[87] *See infra* paras. 85-86, 89. The Anti-Deficiency Act (ADA) prohibits the Commission from making or authorizing an expenditure or obligation that exceeds the amount available for it an appropriation or fund. 31 U.S.C. § 1341; Pub. L. No. 97-258, 96 Stat. 923 (1982); Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, Title XIII, § 13213(a), 104 Stat. 1388-621 (1990). The universal service programs, however, have been exempt from the ADA since 2005, and currently are exempt until December 31, 2007 as part of a one-year exemption set forth in the Revised Continuing Appropriations Resolution of 2007, Pub. L. No. 110-5, 121 Stat. 8 (2007).

[88] The RHC funding year is from June 30 to July 1. *See* 47 C.F.R. § 54.623.

[89] *See supra* para. 21.

(Funding Year 2009 of the existing RHC support mechanism) of the Pilot Program will be approximately $139 million per Pilot Program funding year.[90]

35. *Selected Participants.* Appendix B lists each selected participant's eligible support amounts for each Pilot Program funding year. As indicated in Appendix B, selected participants' available support for each funding year of the Pilot Program is one third of the sum of their Year One and Year Two application funding requests, as calculated by the Commission.[91] We find that committing this funding over a three-year period ensures the Pilot Program remains economically reasonable and fiscally responsible while allowing selected participants to remain eligible to receive their entire eligible Year One and Year Two support as identified in their applications.[92] Although we increase available support amounts, as explained in greater detail below, selected participants may not exceed the available support for each funding year as listed in Appendix B. The selected participants also remain required to provide at least 15 percent of their network costs from other specified sources.[93] In addition, we require that selected participants' network build-outs be completed within five years of receiving an initial FCL.

36. *Priority System.* Contrary to our findings in the *2006 Pilot Program Order*, we also, on our own motion, modify the Pilot Program structure by declining to establish a funding priority system similar to the priority system provided for in the universal service schools and libraries mechanism. In the *2006 Pilot Program Order*, we found that applications for support under the existing RHC support mechanism would be funded before funding any of the projects proposed in the Pilot Program.[94] We had limited funding for the Pilot Program to the difference between the amount committed to the existing RHC support mechanism and $100 million.[95] We find it is not necessary to establish a priority system for the rural health care program because we have eliminated the $100 million cap on funding for the existing RHC support mechanism and the Pilot Program. As such, our expansion of the Pilot Program will ensure that both the applicants under the existing RHC support mechanism and those under the Pilot Program receive funding for all eligible expenses they have included in their applications.

C. Qualifications of Selected Participants

37. In the *2006 Pilot Program Order*, we instructed applicants to indicate how they plan to fully utilize a broadband network to provide health care services and to present a strategy for aggregating the specific needs of health care providers within a state or region, including providers that serve rural areas.[96] Overall, selected participants demonstrated significant need for RHC Pilot Program funding for health care broadband infrastructure and services for their identified health care facilities, and provided the Commission with sufficiently detailed proposals.[97] In their applications, each selected participant explained the goals and objectives of their proposed networks and generally addressed other criteria on

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[90] The funding total is capped by the maximum amount allowable funding for each applicant during the three-year period.

[91] Calculations are based on 85 percent of each selected participant's funding request. For selected participants that did not clearly request 85 percent funding for their total costs, we have adjusted the support level to the appropriate 85 percent level.

[92] *See* 47 U.S.C. § 254(h)(2)(A).

[93] *See infra* Part III.E.3.

[94] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11115, para. 12

[95] *Id.*

[96] *Id.* at 11116, para. 16.

[97] *Id.*

which we sought information in the *2006 Pilot Program Order*.[98] In addition, each selected participant must comply with all Pilot Program administrative requirements discussed below to receive universal service support funding.[99]

38. *Network Utilization.* In the *2006 Pilot Program Order*, we set forth the network goals and objectives for applicants to meet to be considered for Pilot Program funding. In particular, we requested that applicants indicate how they will utilize dedicated broadband capacity to provide health care services.[100] Selected participants sufficiently set forth the various ways in which they would appropriately utilize a broadband network.[101] For example, Virginia Acute Stroke Telehealth Project proposes a broadband network that would focus on the continuum of care (prevention through rehabilitation) for stroke patients in rural and underserved areas of Virginia.[102] Illinois Rural HealthNet

[98] *Id.* at 11116-17, paras. 16-17. Selected participants must meet the goals and objectives they identified in their Pilot Program applications.

[99] *See infra* Part III.E.

[100] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 16.

[101] Arizona Rural Community Health Information Exchange Application at 7-8; Iowa Rural Health Telecommunications Program Application at 7-8, 12-13; Northeast HealthNet Application at 4; Southwest Alabama Mental Health Consortium Application at Section B; Mountain States Health Alliance Application at 1; University Health Systems of Eastern Carolina Application at 6; University of Mississippi Medical Center Application at 2, 19; Western Carolina University Application at 4, 6; Alabama Pediatric Health Access Network Application at 5, 9, 12; Colorado Health Care Connections Application at 10; Heartland Unified Broadband Network Application at 3, 15-17; Juniata Valley Network Application at 5, 22-28; Michigan Public Health Institute Application at 3-7; Frontier Access to Healthcare in Rural Montana Application at 1; Northeast Ohio Regional Health Information Organization Application at 3, 5-6; Pacific Broadband Telehealth Demonstration Project Application at 3-13; Rural Wisconsin Health Cooperative Application at 1-3; Southwest Telehealth Access Grid Application at 6; Big Bend Regional Healthcare Information Organization Application at 3; Geisinger Health System Application at 2-3; Indiana Health Network Application at 53; Northwest Alabama Mental Health Center at 1; Oregon Health Network Application at 17-20; St. Joseph's Hospital Application at 4; Health Care Research & Education Network at 12-23; Alaska Native Tribal Health Consortium Application at 12; Bacon County Health Services Application at 1; California Telehealth Network Application at 9; Missouri Telehealth Network Application at 4, 7; New England Telehealth Consortium Application at 15-16; North Country Telemedicine Project Application at 7-8; Rocky Mountain HealthNet Application at 3; Texas Health Information Network Collaborative Application at 7; Wyoming Telehealth Network Application at 19; Adirondack-Champlain Telemedicine Information Network Application at 15-22; Association of Washington Public Hospital Districts Application at 7, 23-26; Holzer Consolidated Health Systems Application at 2, 5; North Carolina Telehealth Network Application at 3-4; Palmetto State Providers Network at 4-6; Penn State Milton S. Hershey Medical Center Application at 6-8; Rural Healthcare Consortium of Alabama Application at 1-3; Pathways Community Behavioral Healthcare, Inc. Application at 2; West Virginia Telehealth Alliance Application at 34-50; Virginia Acute Stroke Telehealth Project Application at 22, 25-29; Rural Nebraska Healthcare Network Application at 14-16, 32-35; Southern Ohio Healthcare Network Application at 3; Texas Healthcare Network Application at 11; Iowa Health System Application at 5; Rural Western and Central Maine Broadband Initiative Application at 26-28; Tennessee Telehealth Network Application at 23-24; DCH Health System Application at 2; Albemarle Network Telemedicine Initiative Application at 1; Kansas University Medical Center at 2; Western New York Rural Area Health Education Center Application at 3; Health Information Exchange of Montana Application at 5; Arkansas Telehealth Network Application at 3-4; As One-Together for Health Application at 8; Communicare Application at 12; Erlanger Health System Application at 2-3; Greater Minnesota Telehealth Broadband Initiative Application at 5, 17, 44-45; Illinois Rural HealthNet Consortium Application at Attachment 1; Kentucky Behavioral Telehealth Network Application at 5-6; Pennsylvania Mountains Healthcare Alliance Application at 8-9; Tohono O'odham Nation Department of Information Technology Application at 4; Louisiana Department of Hospitals Application at 3; Northwestern Pennsylvania Telemedicine Initiative Application at 1; Puerto Rico Health Department Application at 2-3; Sanford Health Collaboration and Communication Channel Application at 3; Utah Telehealth Network Application at 19-20.

[102] Virginia Acute Stroke Telehealth Project Application at 21-22, 25.

Consortium plans to use its network for a wide variety of telemedicine applications, including video conferencing, remote doctor-patient consultations, and telepsychiatry.[103] Pacific Broadband Telehealth Demonstration Project seeks to interconnect seven existing networks to link health care providers throughout Hawaii and the Pacific Island region.[104] The network will enable delivery of broadband telehealth and telemedicine for clinical applications, continuing medical, nursing and public health education, and electronic health records support.[105] Alaska Native Tribal Health Consortium plans to connect rural health care providers throughout Alaska to urban health centers *via* a network that will support teleradiology, electronic medical records, and telepsychiatry through video conferencing.[106]

39. Based on our review of all 81 of the applications, we find that the 69 selected participants have shown that they intend to utilize dedicated health care network capacity consistent with the goals set forth in the *2006 Pilot Program Order*. Thus, in selecting these applicants as eligible to receive funding for broadband infrastructure and services, we will advance the goals of, among other things, bringing the benefits of telehealth and telemedicine to areas where the need for these benefits is most acute; allowing patients to access critically needed specialists in a variety of practices;[107] and enhancing the health care community's ability to provide a rapid and coordinated response in the event of a national health care crisis.[108]

40. *Leveraging of Existing Technology.* In the *2006 Pilot Program Order*, we stated that applicants should leverage existing technology to adopt the most efficient and cost-effective means of connecting providers.[109] We explained that the Pilot Program would be "technically feasible" because it would not require development of any new technology, but rather would enable participants to utilize any currently available technology.[110] In general, selected participants explained how their proposed networks would leverage existing technology.[111] Examples of applicants leveraging existing technology

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[103] Illinois Rural HealthNet Consortium Application at 9.

[104] Pacific Broadband Telehealth Demonstration Project Application at 4-8.

[105] *Id.* at 3.

[106] Alaska Native Tribal Health Consortium Application at 9, 12-14.

[107] *2006 Pilot Program Order*, 21 FCC Rcd at 11111, paras. 1-2. *See, e.g.*, Virginia Acute Stroke TeleHealth Project Application at 14-16 (explaining that the differential diagnosis and treatment of a stroke within the first three hours is critical for effective patient care).

[108] *2006 Pilot Program Order*, 21 FCC Rcd at 11111, paras. 1-2. *See, e.g.*, Bacon County Health Services Application at 1-2 (noting that its goal to enhance a rapid and coordinated response by health care providers in the event of a national crisis is especially important to residents in its area, many of whom live within 10 to 50 miles of Plant Hatch, a nuclear energy plant).

[109] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 16.

[110] *Id.* at 11114, para. 11; *see also* 47 U.S.C. § 254(h)(2)(A).

[111] Iowa Rural Health Telecommunications Program Application at 4, 6, 8; Northeast HealthNet Application at 6; Mountain States Health Alliance Application at 1; University Health Systems of East Carolina Application at 4, 5; Western Carolina University Application at 10; Alabama Pediatric Health Access Network Application at 16; Colorado Health Care Connections Application at 7; Heartland Unified Broadband Network Application at 3, 9; Juniata Valley Network Application at 6-7, 35; Michigan Public Health Institute Application at 29-31; Frontier Access to Healthcare in Rural Montana at 13-16; Northeast Ohio Regional Health Information Organization Application at 11, 18; Pacific Broadband Telehealth Demonstration Project Application at 3-13; Rural Wisconsin Health Cooperative Application at 4; Southwest Telehealth Access Grid Application at 1, 2, 6; Big Bend Regional Healthcare Information Organization Application at 2-12; Geisinger Health System Application at 3-4; Indiana Health Network Application at 63; Oregon Health Network Application at 17-20; St. Joseph's Hospital Application at 2; Health Care Research & Education Network Application at 13-15; Alaska Native Tribal Health Consortium Application at 12; Bacon County Health Services Application at 6; Missouri Telehealth Network Application at 9; (continued....)

include the Association of Washington Public Hospital Districts, which plans to create a "network of networks" by interconnecting six existing networks to create a statewide network.[112] And Colorado *Health Care Connections proposes to leverage an existing state network as the basis for a dedicated health* care network for Colorado's public and non-profit health care providers.[113] The goal is to connect all 50 rural hospitals and 76 rural clinics to the state network, which in turn is connected to the major metropolitan tertiary hospitals, and Internet2 and NLR.[114]

41. *Aggregation.* In the *2006 Pilot Program Order*, we instructed applicants to provide strategies for aggregating the specific needs of health care providers, including providers that serve rural areas within a state or region.[115] In general, selected participants sufficiently explained how their proposed networks would aggregate the needs of health care providers, including rural health care providers.[116] For

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New England Telehealth Consortium Application at 12-13; North Country Telemedicine Project Application at 13; Rocky Mountain HealthNet Application at 4; Texas Health Information Network Collaborative Application at 10; Adirondack-Champlain Telemedicine Information Network Application at 36-37; Association of Washington Public Hospital Districts Application at 28; North Carolina Telehealth Network Application at 11-12; Palmetto State Providers Network Application at 7; Penn State Milton S. Hershey Medical Center Application at 9; Rural Healthcare Consortium of Alabama Application at 3, 5; Pathways Community Behavioral Healthcare, Inc. Application at 3; West Virginia Telehealth Alliance Application at 2, Attachment 1; Virginia Acute Stroke Telehealth Project Application at 34-35; Rural Nebraska Healthcare Network Application at 28; Southern Ohio Healthcare Network Application at 4, 21; Texas Healthcare Network Application at 13; Iowa Health System Application at 5; Rural Western and Central Maine Broadband Initiative Application at 24, 47-48; Tennessee Telehealth Network Application at 8, 12; DCH Health System Application at 1-2; Kansas University Medical Center Application at 5-6; Western New York Rural Area Health Education Center Application at 4; Arkansas Telehealth Network Application at 12; As One - Together for Health Application at 12; Communicare Application at 11; Erlanger Health System Application at 4; Greater Minnesota Telehealth Broadband Initiative Application at 17-38; Illinois Rural HealthNet Consortium Application at 15; Pennsylvania Mountains Healthcare Alliance Application; Louisiana Department of Hospitals Application at 6; Northwestern Pennsylvania Telemedicine Initiative Application at 4-5; Puerto Rico Health Department Application at 7-8; Sanford Health Collaboration and Communication Channel Application at 4, Appendix C; Utah Telehealth Network Application at 27.

[112] Association of Washington Public Hospital Districts Application at 6, 28.

[113] Colorado Health Care Connections Application at 1.

[114] *Id.* at 7.

[115] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 16.

[116] *See id.* Arizona Rural Community Health Information Exchange Application at 3; Iowa Rural Health Telecommunications Program Application at 7-8; Northeast HealthNet Application at 7, 10; Southwest Alabama Mental Health Consortium Application at Section B; Mountain States Health Alliance Application at 1; University Health Systems of Eastern Carolina Application at 5-6; University of Mississippi Medical Center Application at 2, 4; Western Carolina University Application at 4; Alabama Pediatric Health Access Network Application at 8; Colorado Health Care Connections Application at 11-12; Heartland Unified Broadband Network Application at 3, 9; Juniata Valley Network Application at 6-7, 35; Michigan Public Health Institute Application at 27; Frontier Access to Healthcare in Rural Montana Application at 10; Northeast Ohio Regional Health Information Organization Application at 18-19; Pacific Broadband Telehealth Demonstration Project Application at 3-13; Rural Wisconsin Health Cooperative Application at 4; Southwest Telehealth Access Grid Application at 12; Big Bend Regional Healthcare Information Organization Application at 2-12; Indiana Health Network Application at 63; Oregon Health Network Application at 21-30; St. Joseph's Hospital Application at 3; Health Care Research & Education Network at 12-23; Alaska Native Tribal Health Consortium Application at 9; Bacon County Health Services Application at 3, 6; California Telehealth Network Application at 69-70; Missouri Telehealth Network Application at 3; New England Telehealth Consortium Application at 11-12; North Country Telemedicine Project Application at 4, 13; Rocky Mountain HealthNet Application at 4; Texas Health Information Network Collaborative Application at 10; Wyoming Telehealth Network Application at 1; Adirondack-Champlain Telemedicine Information Network Application at 25-26; Association of Washington Public Hospital Districts Application at 28-29; Holzer Consolidated Health Systems Application at 8; North Carolina Telehealth Network Application at 5, 8; Palmetto (continued....)

example, Palmetto State Providers Network plans to link large tertiary centers, academic medical centers, rural hospitals, community health centers, and rural office-based practices in four separate rural/underserved areas in South Carolina into a developing fiber optic statewide backbone which connects to Internet2, NLR, and the public Internet.[117] Similarly, Iowa Rural Health Telecommunications Program plans to link 100 hospitals in 57 counties in Iowa, one Nebraska hospital, and two South Dakota hospitals to a broadband network which will: facilitate timely diagnosis and initiation of appropriate treatment or transfer of patients in rural communities; facilitate rapid access to and transmission of diagnostic images and patient information between hospitals; extend and improve terrorism and disaster preparedness and response through communication network interoperability between hospitals, the Iowa Department of Public Health, and Iowa Homeland Security and Emergency Management; and enable future remote monitoring and care coordination for intensive care patients.[118]

42. *Creation of Statewide or Regional Health Care Networks and Connection to Dedicated Nationwide Backbone.* In the *2006 Pilot Program Order*, we instructed applicants to submit proposals that would facilitate the creation of state or regional networks and (optionally) connect to a nationwide broadband network. These networks should be dedicated to health care, thereby connecting public and non-profit health care providers in rural and urban locations.[119] The selected participants generally demonstrated how their proposals would result in new or expanded state or regional networks and connection to a nationwide broadband network dedicated to health care.[120] For example, Wyoming

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State Providers Network Application at 5, 7, 22, 57-58; Penn State Milton S. Hershey Medical Center Application at 6; Rural Healthcare Consortium of Alabama Application at 2; Pathways Community Behavioral Healthcare, Inc. Application at 3; West Virginia Telehealth Alliance Application at 1-2; Virginia Acute Stroke TeleHealth Project Application at 31; Rural Nebraska Healthcare Network Application at 10; Southern Ohio Healthcare Network Application at 4, 15-16; Texas Healthcare Network Application at 6; Iowa Health System Application at 6; Rural Western and Central Maine Broadband Initiative Application at 11-12, 26; Tennessee Telehealth Network Application at 30; DCH Health System Application at 3; Kansas University Medical Center Application at 5; Western New York Rural Area Health Education Center Application at 16; Health Information Exchange of Montana Application at 2, 9; Arkansas Telehealth Network Application at 32-33; Communicare Application at 7; Erlanger Health System Application at 5; Greater Minnesota Telehealth Broadband Initiative Application at 12-13; Illinois Rural HealthNet Consortium Application at 14; Pennsylvania Mountains Healthcare Alliance Application at 6-8; Tohono O'odham Nation Department of Information Technology Application at 3-4; Louisiana Department of Hospitals Application at 10-11; Northwestern Pennsylvania Telemedicine Initiative Application at 3; Puerto Rico Health Department Application at 10; Sanford Health Collaboration and Communication Channel Application at 2; Utah Telehealth Network Application at 20-24.

[117] Palmetto State Providers Network Application at 5.

[118] Iowa Rural Health Telecommunications Program Application at 7-8, 12-13.

[119] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111, 11115-16, paras. 2, 16.

[120] *See infra* paras. 83-98, explaining the USAC application process, which will require selected participants to provide, *inter alia*, detailed information on their creation of, and connection to, networks, to receive Pilot Program funds. Arizona Rural Community Health Information Exchange Application at 26; Iowa Rural Health Telecommunications Program Application at 7, 12, 14; Northeast HealthNet Application at 8; Southwest Alabama Mental Health Consortium Application at Section B; Mountain States Health Alliance Application at 1; University Health Systems of Eastern Carolina Application at 5; University of Mississippi Medical Center Application at 2; Alabama Pediatric Health Access Network Application at 9; Colorado Health Care Connections Application at 11-12; Heartland Unified Broadband Network Application at 2; Juniata Valley Network Application at 6-7, 35; Michigan Public Health Institute Application at 1, 4; Frontier Access to Healthcare in Rural Montana Application at 10, 15; Northeast Ohio Regional Health Information Organization Application at 13; Pacific Broadband Telehealth Demonstration Project Application at 1, 2, 6, 8, Appendix 1; Rural Wisconsin Health Cooperative Application at 1; Southwest Telehealth Access Grid Application at 12; Big Bend Regional Healthcare Information Organization Application at 4-10; Geisinger Health System Application at 5; Indiana Health Network Application at 63; Northwest Alabama Mental Health Center Application at 2; Oregon Health Network Application at 21-30; St. Joseph's Hospital Application at 2; Health Care Research & Exchange Network Application at 12-23; Alaska Native (continued....)

Telehealth Network will connect more than 30 hospitals and 42 community health centers, providing consortium health care professionals with access to a statewide network, and facilitating connection to Internet2 or NLR.[121] West Virginia Telehealth Alliance's proposed network will facilitate access in every region, health care market, and community in West Virginia, with particular focuses on medically underserved rural areas; health professional shortage areas; communities with high disease and chronic health condition disparities; and communities that demonstrate "readiness for deployment."[122] Southwest Alabama Mental Health Consortium plans to establish a broadband network connecting 34 mental health providers in 16 counties in Southwest Alabama, and this network will connect to Internet2 thereby creating a large regional mental health care network that has access to the national backbone.[123]

43. *Tribal Lands.* A significant number of applicants plan to use Pilot Program funds to create or expand health care networks serving tribal lands.[124] We find that network reach to tribal lands to be a positive use of Pilot Program funds; these areas traditionally have been underserved by health care facilities and reflect unique health care needs, particularly compared to non-tribal areas.[125] In addition to inadequate access to health care, tribal lands suffer from relatively low levels of access to important

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Tribal Health Consortium Application at 12; Bacon County Health Services Application at 2; California Telehealth Network Application at 12; Missouri Telehealth Network Application at 3; New England Telehealth Consortium Application at 12; North Country Telemedicine Project Application at 11; Rocky Mountain HealthNet Application at 5; Texas Health Information Network Collaborative Application at 10, 24; Wyoming Telehealth Network Application at 8-9; Adirondack-Champlain Telemedicine Information Network Application at 2; Association of Washington Public Hospital Districts Application at 6; Holzer Consolidated Health Systems Application at 2-3; North Carolina Telehealth Network Application at 5, 11; Palmetto State Providers Network Application at 22; Penn State Milton S. Hershey Medical Center Application at 6; Rural Healthcare Consortium of Alabama Application at 2-3; West Virginia Telehealth Alliance Application at Attachment 1; Virginia Acute Stroke TeleHealth Project Application at 44; Rural Nebraska Healthcare Network Application at 10; Southern Ohio Healthcare Network Application at 15-16, 21; Texas Healthcare Network Application at 12; Iowa Health System Application at 5; Rural Western and Central Maine Broadband Initiative Application at 26; Tennessee Telehealth Network Application at 18-19; Albemarle Network Telemedicine Initiative Application at 2; Kansas University Medical Center Application at 6; Western New York Rural Area Health Education Center Application at 8-9; Health Information Exchange of Montana Application at 7; Arkansas Telehealth Network Application at 10-12; As One-Together for Health Application at 4-9; Communicare Application at 7; Erlanger Health System Application at 2, 13; Greater Minnesota Telehealth Broadband Initiative Application at 10-11; Illinois Rural HealthNet Consortium Application at 15, 18; Kentucky Behavioral Telehealth Network Application at 10-11; Pennsylvania Mountains Healthcare Alliance Application at 4; Tohono O'odham Nation Department of Information Technology Application at 4; Louisiana Department of Hospitals Application at 10-12; Northwestern Pennsylvania Telemedicine Initiative Application at 2-3; Puerto Rico Health Department Application at 13; Sanford Health Collaboration and Communication Channel Application at 2; Utah Telehealth Network Application at 20-24.

[121] Wyoming Telehealth Network Application at 8-10.

[122] West Virginia Telehealth Alliance Application at 26 of Strategic Plan.

[123] Southwest Alabama Mental Health Consortium Application at Section B.

[124] *See, e.g.*, Western Carolina University Application at 10; Heartland Unified Broadband Network Application at Appendix F; Michigan Public Health Institute Application at 34-35; Southwest Telehealth Access Grid Application at 1; Oregon Health Network Application at 22; Health Care Research & Education Network Application at 10; California Telehealth Network Application at 55; Adirondack-Champlain Telemedicine Information Network Application at 10-14; Association of Washington Public Hospital Districts Application at 18-22; Rural Nebraska Healthcare Network Application at 7; Health Information Exchange of Montana Application at 8; Tohono O'odham Nation Department of Information Technology Application at 10-16; Sanford Health Collaboration and Communication Channel Application at 5; Utah Telehealth Network Application at 2, 4, 5, 7, 32.

[125] U.S. Department of Health and Human Services, Indian Health Service, Facts on Indian Health Disparities, *available at* http://info.ihs.gov/Files/DisparitiesFacts-Jan2007.doc (last visited Nov. 15, 2007).

telecommunications services. For example, Native American communities have the lowest reported levels of telephone subscribership in America.[126]

44. We find that these health care and telecommunications disparities between tribal lands and other areas of the country underscore the serious need for Pilot Program support of telemedicine and telehealth networks in tribal areas. Many selected participants plan to use Pilot Program support for networks on or near tribal lands. For example, Health Care Research & Education Network (Network) plans to construct a network that will serve a significant Native American population. According to the Network, Native Americans report being uninsured at a rate of 37.1 percent and North Dakota's Indian population is 1.5 times as likely to die of heart disease, cancer, stroke, and influenza/pneumonia as those living on non-tribal lands.[127] The Network seeks to alleviate some of these disparities through use of its planned network that will provide a link to improve educational opportunities, and will facilitate new and ongoing research in health care delivery to rural areas.[128]

45. In the first year of the Pilot Program, Western Carolina University (WCU) in collaboration with the Eastern Band of Cherokee Indians (EBCI) seeks to connect the WCU's health care facilities to health care facilities on the ECBI reservation and in outlying areas so that patients can access critically needed medical specialists in a variety of practices without leaving their homes or their communities.[129] In Year two of the Pilot Program, WCU plans to connect the United South and Eastern Tribes, Inc. (USET), a non-profit, inter-tribal organization of 24 federally recognized tribes, to its network.[130] We find that these and the other planned uses of Pilot Program funds to support network build-out to tribal lands will further our goal of bringing innovative health care services to those areas of the country with the most acute health care needs.[131]

46. *Cost Estimates.* In the *2006 Pilot Program Order* we requested that applicants provide estimates of their network's total costs for each year.[132] Selected participants provided cost estimates or budgets.[133] Several applicants provided significant cost and budget details, including Adirondack-

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[126] *See, e.g., Sacred Wind Communications, Inc. and Qwest Corporation, Joint Petition for Waiver of the Definition of "Study Area" Contained in Part 36, Appendix-Glossary of the Commission's Rules, Sacred Wind Communications, Inc., Related Waivers of Parts 36, 54, and 69 of the Communication's Rules*, CC Docket No. 96-45, Order, 21 FCC Rcd 9227, 9231 para. 9 (2006); *see also Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Memorandum Opinion and Order, and Further Notice of Proposed Rulemaking, 15 FCC Rcd 12208, 12217-18, para. 16 (2000) (amending Lifeline and Link-Up assistance rules applicable to eligible residents of tribal lands, consisting of qualifying low-income consumers living on or near reservations, as defined in 25 C.F.R. § 20.1(r), (v)); *Federal-State Joint Board on Universal Service; Promoting Deployment and Subscribership in Unserved and Underserved Areas, Including Tribal and Insular Areas*, CC Docket No. 96-45, Order and Further Notice of Proposed Rulemaking, 15 FCC Rcd 17122 (2000) (seeking additional comment on extending the enhanced Lifeline and Link-Up measures to qualifying low-income consumers living in areas near reservations to target support to the most underserved, geographically isolated, and impoverished areas that are characterized by low subscribership).

[127] Health Care Research & Education Network Application at 8.

[128] *Id.*

[129] Western Carolina University Application at 3, 10.

[130] Western Carolina University Application at 10-11.

[131] *2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1.

[132] *Id.* at 11111-12, 11116-17, paras. 3, 17.

[133] Arizona Rural Community Health Information Exchange Application at 13, 15; Iowa Rural Health Telecommunications Program Application at 15; Northeast HealthNet Application at 10-11; Southwest Alabama Mental Health Consortium Application at Section D; Mountain States Health Alliance Application at 1, 6, 8; University Health Systems of Eastern Carolina Application at 7, 16; University of Mississippi Medical Center (continued....)

Champlain Telemedicine Information Network whose budget includes a clear and detailed analysis of network costs, including, *e.g.*, cost per foot of fiber, cost of a pole installation, number of feet of fiber, and number of poles where fiber is installed.[134] Alaska Native Tribal Health Consortium provides detailed cost estimates for each phase of its network, including deployment and services, and provides significant information about its revenue stream, operating expenses, and maintenance for five years.[135] Although we find selected participants have satisfied this criterion, to ensure support is used for eligible costs, as part of the USAC application process, applicants must submit detailed network costs worksheets.[136]

47. *Fair Share.* To prevent improper distribution of Pilot Program funds, in the *2006 Pilot Program Order*, we instructed applicants to describe how for-profit network participants will pay their fair share of the network and other costs.[137] In general, selected participants provided significant

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Application at 45, 19; Western Carolina University Application at 8; Alabama Pediatric Health Access Network Application at 37-38; Colorado Health Care Connections Application at 13; Heartland Unified Broadband Network Application at 30-32; Juniata Valley Network Application at 50; Michigan Public Health Institute Application at 63-65; Frontier Access to Healthcare in Rural Montana Application at 38; Northeast Ohio Regional Health Information Organization Application at 51-55; Pacific Broadband Telehealth Demonstration Project Application at Appendix 2; Rural Wisconsin Health Cooperative Application at 6; Southwest Telehealth Access Grid Application at 40; Big Bend Regional Healthcare Information Organization Application at 13; Geisinger Health System Application at 4; Indiana Health Network Application at 4-5; Northwest Alabama Mental Health Center Application at 2; Oregon Health Network Application at 37; St. Joseph's Hospital Application at 4; Health Care Research & Education Network Application at 23-24; Alaska Native Tribal Health Consortium Application at 19; Bacon County Health Services Application at 9; California Telehealth Network Application at 22-23; Missouri Telehealth Network Application at 7; New England Telehealth Consortium Application at 18, 37; North Country Telemedicine Project Application at 15, 16; Rocky Mountain HealthNet Application at 7; Texas Health Information Network Collaborative Application at 16; Wyoming Telehealth Network Application at 11; Adirondack-Champlain Telemedicine Information Network Application at 5; Association of Washington Public Hospital Districts Application at 15, 17; Holzer Consolidated Health Systems Application at 12; North Carolina Telehealth Network Application at 13-14; Palmetto State Providers Network Application at 27; Penn State Milton S. Hershey Medical Center Application at 9-10; Rural Healthcare Consortium of Alabama Application at 6; Pathways Community Behavioral Healthcare, Inc. Application at 1, 3; West Virginia Telehealth Alliance Application at Appendix 2; Virginia Acute Stroke TeleHealth Project Application at 77; Rural Nebraska Healthcare Network Application at 37; Southern Ohio Healthcare Network Application at 25; Texas Healthcare Network Application at 12; Iowa Health System Application at 5; Rural Western and Central Maine Broadband Initiative Application at 24; Tennessee Telehealth Network Application at 25; DCH Health System Application at 4; Albemarle Network Telemedicine Initiative Application at 2; Kansas University Medical Center Application at 8, 16; Western New York Rural Area Health Education Center Application at 18; Health Information Exchange of Montana Application at 13; Arkansas Telehealth Network Application at 56-58; As One-Together for Health Application at 12; Communicare Application at 23; Erlanger Health System Application at 12; Greater Minnesota Telehealth Broadband Initiative Application at 2; Illinois Rural HealthNet Consortium Application at 30; Kentucky Behavioral Telehealth Network Application at 18-21; Pennsylvania Mountains Healthcare Alliance Application at 3; Tohono O'odham Nation Department of Information Technology Application at Appendix B; Louisiana Department of Hospitals Application at 14; Northwestern Pennsylvania Telemedicine Initiative Application at 11; Puerto Rico Health Department Application at 13, Appendix F; Sanford Health Collaboration and Communication Channel Application at 4, 10; Utah Telehealth Network Application at 3, 47.

[134] Adirondack-Champlain Telemedicine Information Network Application at 5-9.

[135] Alaska Native Tribal Health Consortium Application at 19, 50.

[136] Below, we provide selected participants with an illustrative format for identifying all of the information that should be included in their budgets. *See infra* at Appendix F.

[137] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17.

assurances that for-profit participants will be responsible for all of their network costs.[138] For instance, Northeast HealthNet states that its proposed network does not include for-profit entities and that, if for-profit entities are added to its network, they would be invoiced separately for each service item and USAC would receive invoice documentation that reflects only eligible rural health care providers.[139] Similarly, TTN notes that although it will not include for-profit participants in the first two years, for-profits will later be allowed to join and will be required to pay 100 percent of their actual costs.[140]

48. *Funding Source.* In the *2006 Pilot Program Order*, we instructed applicants to identify their source of financial support and anticipated revenues that will pay for costs not covered by the fund.[141] Generally, selected participants identified their source or sources of support for costs not covered by the Pilot Program.[142] For example, University Health Systems of Eastern Carolina states that it, the

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[138] Arizona Rural Community Health Information Exchange Application at 18; Iowa Rural Health Telecommunications Program Application at 19; Northeast HealthNet Application at 11; Mountain States Health Alliance Application at 6; University Health Systems of Eastern Carolina Application at 7; University of Mississippi Medical Center Application at Attachment to p. 45; Western Carolina University Application at 9; Heartland Unified Broadband Network Application at 20, 34; Juniata Valley Network Application at 36; Michigan Public Health Institute Application at 24; Frontier Access to Healthcare in Rural Montana Application at 16; Northeast Ohio Regional Health Information Organization Application at 7-8; Pacific Broadband Telehealth Demonstration Project Application at 14; Rural Wisconsin Health Cooperative Application at 6; Big Bend Regional Healthcare Information Organization Application at 4; Geisinger Health System Application at 4; Indiana Health Network Application at 70; Northwest Alabama Mental Health Center Application at 2; Oregon Health Network Application at 92; St. Joseph's Hospital Application at 4; Health Care Research & Education Network Application at 25; Alaska Native Tribal Health Consortium Application at 13; Bacon County Health Services Application at 2; California Telehealth Network Application at 24; Missouri Telehealth Network Application at 4; New England Telehealth Consortium Application at 18; North Country Telemedicine Project Application at 17; Rocky Mountain HealthNet Application at 2, 7; Texas Health Information Network Collaborative Application at 26; Wyoming Telehealth Network Application at 11; Adirondack-Champlain Telemedicine Information Network Application at 9; Association of Washington Public Hospital Districts Application at 16; Holzer Consolidated Health Systems Application at 6; North Carolina Telehealth Network Application at 15; Palmetto State Providers Network Application at 9, 23; Penn State Milton S. Hershey Medical Center Application at 10; Rural Healthcare Consortium of Alabama Application at 3; Pathways Community Behavioral Healthcare, Inc. Application at 3; West Virginia Telehealth Alliance Application at 8-9; Virginia Acute Stroke TeleHealth Project Application at 53; Rural Nebraska Healthcare Network Application at 37; Southern Ohio Healthcare Network Application at 23-24; Texas Healthcare Network Application at 17; Iowa Health System Application at 6; Rural Western and Central Maine Broadband Initiative Application at 45-46; Tennessee Telehealth Network Application at 26; Albemarle Network Telemedicine Initiative Application at 2; Arkansas Telehealth Network Application at 54; As One-Together for Health Application at 13; Communicare Application at 24; Erlanger Health System Application at 5; Greater Minnesota Telehealth Broadband Initiative Application at 2; Illinois Rural HealthNet Consortium Application at 30; Tohono O'odham Nation Department of Information Technology Application at 18; Louisiana Department of Hospitals Application at 24; Northwestern Pennsylvania Telemedicine Initiative Application at 4; Puerto Rico Health Department Application at 13; Sanford Health Collaboration and Communication Channel Application at 4; Utah Telehealth Network Application at 50.

[139] Northeast HealthNet Application at 11.

[140] Tennessee TeleHealth Network Application at 26.

[141] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17. To preserve the integrity of the Pilot Program, we will continue to require selected participants to indicate how for-profit participants pay their fare share of network costs. Accordingly, selected participants must submit this information to USAC as part of their detailed line-item network costs worksheet submission and Pilot Program Participants Quarterly Data Reports. *See* Appendices D, F; *see also* Part III.E.3, *infra* (describing eligible funding sources).

[142] Arizona Rural Community Health Information Exchange Application at 14; Iowa Rural Health Telecommunications Program Application at 19; Northeast HealthNet Application at 11; Southwest Alabama Mental Health Consortium Application at Section E; Mountain States Health Alliance Application at 7; University (continued....)

participating health care providers, and the North Carolina Office of Rural Health will provide funding for their network costs not supported by Pilot Program funds.[143] And, Wyoming Telehealth Network has received a commitment from the Wyoming Department of Public Health and Terrorism Preparedness Program to fund the Network's costs not covered by the Program.[144]

49. *85 Percent Funding.* We also stated in the *2006 Pilot Program Order* that no more than 85 percent of their costs incurred by a participant will be funded to deploy a state or regional dedicated broadband health care network, and to connect that network to NLR, Internet2, or the public Internet.[145] In general, selected participants demonstrated their commitment to seeking no more than 85 percent of their network costs from the Pilot Program.[146] Michigan Public Health Institute, for example, explains

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Health Systems of Eastern Carolina Application at 7, Appendixes A, B, C, D; Western Carolina University Application at 9; Alabama Pediatric Health Access Network Application at 6, 9; Colorado Health Care Connections Application at 17; Heartland Unified Broadband Network Application at 34, Appendix D; Juniata Valley Network Application at 55; Michigan Public Health Institute Application at 61-62; Frontier Access to Healthcare in Rural Montana Application at 17, Letters of Commitment; Northeast Ohio Regional Health Information Organization Application at 7, 52-54; Pacific Broadband Telehealth Demonstration Project Application at 14; Rural Wisconsin Health Cooperative Application at 6; Southwest Telehealth Access Grid Application at Appendix 5; Big Bend Regional Healthcare Information Organization Application at 14-15; Indiana Health Network Application at 68; Northwest Alabama Mental Health Center Application at 3; Oregon Health Network Application at 86; St. Joseph's Hospital Application at 5; Health Care Research & Education Network Application at 25; Alaska Native Tribal Health Consortium Application at 23; Bacon County Health Services Application at 8; California Telehealth Network Application at 26; Missouri Telehealth Network Application at 5, 14, Attachment C; New England Telehealth Consortium Application at 19, Appendix C; North Country Telemedicine Project Application at 13; Rocky Mountain HealthNet Application at 2, 8; Texas Health Information Network Collaborative Application at 17; Wyoming Telehealth Network Application at 11; Adirondack-Champlain Telemedicine Information Network Application at 8; Association of Washington Public Hospital Districts Application at 15; Holzer Consolidated Health Systems Application at 7; North Carolina Telehealth Network Application at 15; Palmetto State Providers Network Application at 8; Penn State Milton S. Hershey Medical Center Application at 10; Rural Healthcare Consortium of Alabama Application at 3-4; Pathways Community Behavioral Healthcare, Inc. Application at 3; West Virginia Telehealth Alliance Application at 9; Virginia Acute Stroke TeleHealth Project Application at 1; Rural Nebraska Healthcare Network Application at 30, 37-38; Southern Ohio Healthcare Network Application at 14; Texas Healthcare Network Application at 17; Iowa Health System Application at 7; Rural Western and Central Maine Broadband Initiative Application at 13; Tennessee Telehealth Network Application at 8, 25-26; Albemarle Network Telemedicine Initiative Application at 14; Kansas University Medical Center Application at 9; Western New York Rural Area Health Education Center Application at 22; Arkansas Telehealth Network Application at 13-14; As One-Together for Health Application at 14; Communicare Application at 24; Erlanger Health System Application at 1; Greater Minnesota Telehealth Broadband Initiative Application at 2; Pennsylvania Mountains Healthcare Alliance Application at 12; Tohono O'odham Nation Department of Information Technology Application at Appendix D; Utah Telehealth Network Application at 49; Sanford Health Collaboration and Communication Channel Application at 4; Puerto Rico Department of Health Application at 13; Louisiana Department of Hospitals Application at 10, 14.

[143] University Health Systems of Eastern Carolina Application at 7.

[144] Wyoming Telehealth Network Application at 11.

[145] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 14; *Pilot Program Reconsideration Order*, 22 FCC Rcd at 2556, para. 5.

[146] Arizona Rural Community Health Information Exchange Application at 15; Iowa Rural Health Telecommunications Program Application at 15, 12-13; Northeast HealthNet Application at 11; Southwest Alabama Mental Health Consortium Application at Section F; Mountain States Health Alliance Application at 8-9; University Health Systems of Eastern Carolina Application at Appendix C; University of Mississippi Medical Center Application at Attachment to p. 45; Western Carolina University Application at 9; Colorado Health Care Connections Application at 17-18; Heartland Unified Broadband Network Application at Appendix D; Juniata Valley Network Application at 50, 55; Michigan Public Health Institute Application at 61-62; Frontier Access to Healthcare in Rural Montana Application at 17; Northeast Ohio Regional Health Information Organization (continued....)

that the Michigan Legislature has appropriated funds to cover a portion of its 15 percent share of costs.[147] California Telehealth Network stated that it will receive its 15 percent share from the California Emerging Technology Fund, which is operated by the California Public Utility Commission.[148] Iowa Health System states that it plans to fund approximately 39 percent of the total cost of extending its existing fiber backbone to 78 rural sites.[149]

50. Included Facilities. With respect to health care facilities, we directed applicants in the *2006 Pilot Program Order*: (1) to list the health care facilities that will be included in their networks;[150] and (2) to demonstrate that they will connect more than a *de minimis* number of rural health care providers in their networks.[151] All selected participants satisfied this request by providing the names and details of facilities to be included and by proposing to connect more than a *de minimis* number of rural health care facilities.[152] Although some proposals include only a few rural health care providers, relative to the total number of facilities to be included in these networks, and recognizing the significant benefits these networks will confer on their rural populations, we find these small numbers of rural health care providers are more than *de minimis* when viewed in context. For example, Erlanger Health System's proposed network in Tennessee and Georgia includes five rural health care providers out of a total of 11

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Application at 7, 9-10, 52; Pacific Broadband Telehealth Demonstration Project Application at 14; Rural Wisconsin Health Cooperative Application at 6; Southwest Telehealth Access Grid Application at Appendix 5; Big Bend Regional Healthcare Information Organization Application at 4; Geisinger Health System Application at 4; Indiana Health Network Application at 4-5; Northwest Alabama Mental Health Center Application at 3; Oregon Health Network Application at 8; St. Joseph's Hospital Application at 3; Health Care Research & Education Network Application at 25; Alaska Native Tribal Health Consortium Application at 23; Bacon County Health Services Application at 8-10; California Telehealth Network Application at 26; Missouri Telehealth Network Application at 15; New England Telehealth Consortium Application at 37; North Country Telemedicine Project Application at 14-16; Texas Health Information Network Collaborative Application at 17; Wyoming Telehealth Network Application at 11; Adirondack-Champlain Telemedicine Information Network Application at 5; Association of Washington Public Hospital Districts Application at 15, 17; North Carolina Telehealth Network Application at 15; Palmetto State Providers Network Application at 26-27; Penn State Milton S. Hershey Medical Center Application at 10, Appendix C; Rural Healthcare Consortium of Alabama Application at 3; Pathways Community Behavioral Healthcare, Inc. Application at 3; West Virginia Telehealth Alliance Application at 8-9; Virginia Acute Stroke Telehealth Project Application at 5, 52, 55; Rural Nebraska Healthcare Network Application at 37-39; Southern Ohio Healthcare Network Application at 25; Texas Healthcare Network Application at 17; Iowa Health System Application at 7; Rural Western and Central Maine Application at 12; Tennessee Telehealth Network Application at 26; DCH Health System Application at 4; Albemarle Network Telemedicine Initiative Application at 2; Western New York Rural Area Health Education Center Application at 21; Health Information Exchange of Montana Application at 34; Arkansas Telehealth Network Application at 54; As One-Together for Health Application at 12; Erlanger Health System Application at 12; Greater Minnesota Telehealth Broadband Initiative Application at 2; Illinois Rural HealthNet Consortium Application at 30-31; Kentucky Behavioral Telehealth Network Application at 18-21; Pennsylvania Mountains Healthcare Alliance Application at 3; Tohono O'odham Nation Department of Information Technology Application at 8-9; Louisiana Department of Hospitals Application at 14; Northwestern Pennsylvania Telemedicine Initiative Application at 5; Puerto Rico Health Department Application at 12-13; Sanford Health Collaboration and Communication Channel Application at 4; Utah Telehealth Network Application at 3, 49.

[147] Michigan Public Health Institute Application at 61.

[148] California Telehealth Network Application at 26, 108.

[149] Iowa Health System Application at 6.

[150] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17.

[151] *Id.* at 11116, para. 16.

[152] *See* list of selected participants at Appendix B.

facilities,[153] and Puerto Rico Health Department's proposed network includes six rural health care providers out of a total of 52 facilities.[154] Considering the total number of health care providers to be included in these proposed networks, we find that the number of rural health care providers is more than *de minimis*.

51. *Prior Experience.* To help ensure sufficient skill and competency of Pilot Program participants, in the *2006 Pilot Program Order* we asked whether applicants had previous experience in developing and managing telemedicine programs,[155] and specifically whether applicants had successful track records in developing, coordinating, and implementing telehealth/telemedicine programs within their states or regions.[156] In general, selected participants exhibited experience with telehealth/telemedicine programs, and some exhibited significant, impressive experience in this area.[157] Notably, University Health Systems of Eastern Carolina has been recognized as one of the nation's "100 Most Wired Healthcare Organizations" five of the previous six years by *Hospitals and Health Networks*

[153] Erlanger Health System Application at 8.

[154] Puerto Rico Health Department Application at 13-20.

[155] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17.

[156] *Id.* at 11116, para. 16.

[157] Arizona Rural Community Health Information Exchange Application at 19-20; Iowa Rural Health Telecommunications Program Application at 8, 11, 26-28; Southwest Alabama Mental Health Consortium Application at Section H; Mountain States Health Alliance Application at 7; University Health Systems of Eastern Carolina Application at 2, 5; University of Mississippi Medical Center Application at 8-18; Western Carolina University Application at 4; Alabama Pediatric Health Access Network Application at 6; Colorado Health Care Connections Application at 20-23; Heartland Unified Broadband Network Application at 9; Juniata Valley Network Application at 59-60; Michigan Public Health Institute Application at 69-70; Frontier Access to Healthcare in Rural Montana Application at 18-19, 22, 26, 29; Northeast Ohio Regional Health Information Organization Application at 16-17; Pacific Broadband Telehealth Demonstration Project Application at 19-20; Rural Wisconsin Health Cooperative Application at 8-10; Southwest Telehealth Access Grid Application at 27-32; Big Bend Regional Healthcare Information Organization Application at 21-22; Geisinger Health System Application at 8; Indiana Health Network Application at 29; Northwest Alabama Mental Health Center Application at 4; Oregon Health Network Application at 95; St. Joseph's Hospital Application at 6; Health Care Research & Education Network Application at 25-26; Alaska Native Tribal Health Consortium Application at 5, 8; Bacon County Health Services Application at 5; California Telehealth Network Application at 48-49; Missouri Telehealth Network Application at 3, 6-7, 9, 14; New England Telehealth Consortium Application at 21-23; North Country Telemedicine Project Application at 26; Rocky Mountain HealthNet Application at 23; Texas Health Information Network Collaborative Application at 41; Wyoming Telehealth Network Application at 6, 16-17; Adirondack-Champlain Telemedicine Information Network Application at 15-22; Association of Washington Public Hospital Districts Application at 23-26; Holzer Consolidated Health Systems Application at 9-10; North Carolina Telehealth Network Application at 22; Palmetto State Providers Network Application at 17-18; Penn State Milton S. Hershey Medical Center Application at 18-19; West Virginia Telehealth Alliance Application at 34-50 of Strategic Plan; Virginia Acute Stroke Telehealth Project Application at 5; Rural Nebraska Healthcare Network Application at 41-42; Southern Ohio Healthcare Network Application at 3, 17-18; Texas Healthcare Network Application at 19; Iowa Health System Application at 9; Rural Western and Central Maine Application at 24-25; Tennessee Telehealth Network Application at 13-17; DCH Health System Application at 1; Albemarle Network Telemedicine Initiative Application at 12-13; Kansas University Medical Center Application at 12-13; Western New York Rural Area Health Education Center Application at 26; Health Information Exchange of Montana Application at 24; Arkansas Telehealth Network Application at 17-22; Erlanger Health System Application at 10-11; Greater Minnesota Telehealth Broadband Initiative Application at 17-23; Illinois Rural HealthNet Consortium Application at 19; Kentucky Behavioral Telehealth Network Application at 11-13; Pennsylvania Mountains Healthcare Alliance Application at 16-17; Tohono O'odham Nation Department of Information Technology Application at 19; Louisiana Department of Hospitals Application at 5-6; Northwestern Pennsylvania Telemedicine Initiative Application at 6-7; Puerto Rico Health Department Application at 9-10; Sanford Health Collaboration and Communication Channel Application at 7; Utah Telehealth Network Application at 49, 51-52.